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Opinions and cultural sensitivities of midwives and nurses about providing health care to women seeking asylum[1]

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Abstract

This descriptive and cross-sectional study was carried out to determine opinions and cultural sensitivities of midwives and nurses about providing health care to women seeking asylum. The universe of the research was 491 midwives and nurses worked in this hospital. 216 midwives and nurses were included in the study. A questionnaire and the Intercultural Sensitivity Scale (ISS) were used in the data collection process. 69.4 % of the participants stated they had given care to asylum seekers before. 28.2 % of them reported they felt helpless, 22.5 % felt pity, 15.5 % felt anger, resentment. The ISS mean score of the participants was 75.73+10.1 It was determined in the study that 97.3 % of the participants providing care to asylum seekers had difficulties, and that language problem was the biggest challenge. The participants suggested that the units offering services to asylum seekers should be separate, the personnel should be trained on this matter, and that service guides should be improved for the solution of the problems.

Keywords: Seeking asylum; women; intercultural sensitivity ; nurse; midwife.

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1. Introduction

Migration has been one of the significant elements of social life since the very early days (Adanu and Johnson, 2009:179-181). The number of people emigrating due to the direct or indirect impacts of globalization is increasing every day (Bertucci and Alberti, 2003). Individuals are sometimes forced to emigrate due to undesirable conditions such as war, exile, and natural disasters, and sometimes they emigrate so as to have better living conditions (Yılmaz, 2014:1685-1704). Such terms as emigrant, refugee, and asylum seeker are used when defining people emigrating. While the term "emigrant" is used for people leaving their country willingly in search for a better life, the term "refugee" is used for individuals carrying a justified fear that they will be persecuted due to their race, religion, nationality, affiliation to a certain social group, or political thoughts, and thus leaving their country and unable to return to or unwilling to return to their home country due to their fears (Phillips, 2011). "Asylum seeker", on the other hand, is a term used for individuals whose application for obtaining refugee status has not yet been endorsed (Phillips, 2011; Deniz, 2014:175-204).

The problems related with asylum seekers, who are forced to leave their country due to war or other reasons, and demand for the protection of another country other than their own, have gradually increased, and this has become a global issue that concerns not only the source and target countries but also the whole world (Hatton and Williamson, 2004). Today, with the increase in violence in Syria, Syrian citizens has had to leave their country and started seeking asylum in neighboring countries. This has led a serious flow of asylum seekers towards Turkey (Korkmaz, 2014:37-42). Migration, taking place in our country as well as in the world, influences all migrating individuals physically, socially, and psychologically whatever the reason is. The migration process has a risk of being an unsettling experience for everyone (adult, young, child, woman, man), and all individuals are influenced by this process at different levels (Çalım-İldam et al., 2012:11-19.). People who do not have any legal rights in countries where they have emigrated to go through serious health problems, and they cause critical health problems in societies where they have emigrated to (Burnett and Pell, 2001:544–547; Razum et al., 2001:654-661). The asylum seekers, increasing constantly particularly in the southern border of our country, cause serious problems in the health system as well. Factors such as inadequate nutrition of asylum seekers, problems with language disability, lack of health insurance, social and psychological stress negatively affects health problems of asylum seekers as well as the health of the community. Because these people are facing significant health risks due to unhealthy living conditions before, during and after migration. (Korkmaz, 2014:37-42) War and migration frequently lead to increasing inequality between men and women (Başterzi, 2017:379-387). Women as a risk group are primarily affected from these problems emerging as a result of migration (Adanu and Johnson, 2009:179–181; Llácer et al., 2007:ii4-ii10). Women should be addressed as a priority since their health directly affects the health status of fetuses, babies and children.

Women, as a result of migration, switch to a different environment with respect to language and culture, willingly or reluctantly leaving their family environment where they grew up and social values they were accustomed to (Topçu, 2006:37-42). Women in this transition phase face a lot of stressors such as social isolation, loneliness, language barriers, and cultural differences. Depending on the negative effect of stress on health and lack of coping mechanisms, migrating women confront a lot of health problems stemming from physiological or psychological causes (Farley et al., 2005:213-219). Midwives and nurses have major roles in improving, protecting, diagnosing, providing treatment when necessary, and rehabilitating women's health which is affected by migration.

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Multiculturalism, already existing in Turkish society, requires midwives and nurses to understand cultural diversities and think thoroughly about intercultural relations. Although the literature information about cultural care in midwifery and nursing education is partly sufficient, culture-sensitive care is not applied adequately (Bulduk et al., 2011:25-31).The problems created by cultural differences in the provision of health care have begun to catch more attention with the emergence of asylum seekers. Among those who provide health care, midwives and nurses are the health professionals who mostly get into contact with women seeking asylum.It is important that midwives and nurses should recognize the cultural factors affecting the behaviors of the group they provide care to.

Health care worker's being unable to understand the culture of the individual well may cause communication breaks, conflicts, inequalities, discrimination, racism, and stereotypes in health care (Lea, 1994:307-313). This situation may adversely impact the quality of care and the individual's health. For this reason, it is necessary to determine the obstacles and problems hindering midwives and nurses from giving a culture sensitive care for providing a quality care. Determining the views of midwives and nurses on providing care to asylum seekers and the problems and challenges while giving care is predicted to create opportunities for the solution of these problems, and contribute to improving the quality of the care provided to asylum seekers and the satisfaction of health care workers.

It is reported in the related studies that nurses and midwives have difficulty in providing care to asylum seekers due to language obstacles and cultural differences, their workload increases, and that they feel frustration and disappointment (Tobin and Murbhy-Lawless, 2014:159–169; Henriksen, 2014:279-292; Kelaher and Manderson, 2000: 1-11). The literature review indicated that there was no research in our country investigating the views of midwives and nurses about providing care to asylum seekers. It is thought that this study is a candidate to help close the mentioned gap in the literature.

2. Purpose

This study conducted to determine the views and cultural sensitivities of midwives and nurses on providing health care to asylum seekers.

3. Material and Method

3.1. The Place and time of the study

The data of the study were collected in a women's health education and research hospital in Ankara between September 2015 and October 2015.

3.2. Population and sample selection

A total of 491 midwives and nurses worked in this hospital. 216 subjects were included in the study based on the sampling formula where the number of individuals in the universe is already known. As for the number of midwives and nurses, 119 midwives and 97 nurses were involved in the study by stratifying the sampling based on the total number of midwives and nurses.

3.3. Type of study

Descriptive and cross-sectional design was used in this study.

3.4. Data collection

A questionnaire form and the Intercultural Sensitivity Scale (ISS) were used for collecting the data of the study. The questionnaire form consisted of 23 items designed to determine the socio-demographic characteristics (age, education, economic status, etc.) and work experiences

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(field of work, total work experience, etc.) of midwives and nurses, and their views about providing health care to asylum seekers.

The Intercultural Sensitivity Scale (ISS) is a 5-point Likert-type inventory that was developed by Chen and Starosta (2000) and consists of five emotional dimensions (ranging between 1 strongly disagree and 5 strongly agree), which is necessary to be interculturally sensitive. The Turkish validity and reliability study of the scale was done by Bulduk et al. (2011) and the cronbach α consistency of the scale was found to be 0.72 (5). The cronbach α internal consistency for this study was determined to be 0.81. The scale comprised 24 items and the items 2, 4, 7, 9, 12, 15, 18, 20, and 22 were reverse coded. Following necessary amendments (grouping total work experience, the item "the longest inhabited province" was replaced by "the longest inhabited geographical region", the item "what are you thinking of while giving care to asylum seekers" was replaced by "how are you feeling while giving care to asylum seekers") as a result of the pilot study, data collection forms were finalized.

20 nurses and 20 midwives were administered a pilot study so as to determine the comprehensibility and practicality of the data collection tools. Data collection forms were administered to the participants in a pleasant environment using face-to-face interview technique. Prior to the data collection process, all the participants were informed about the study and their written consent was obtained. The implementation of the forms took about 15-20 minutes.

3.5. Research ethics

Necessary permissions approval for the study were obtained from the Education Planning and Coordination Committee (29.09.2015/78). Permission for the scale used in the study was obtained through e-mail. Written consent of the participants of the study was obtained. Prior to the administration of the study, the participants were informed about the purpose of the study and how to fill in the data collection forms.

3.6. Evaluation of data

The data of the study were analyzed using computer software. All the analyses in the study were done at 95 % confidence interval and the first type error level was considered as 5 %. The following analyses and calculations were used in the data analysis: frequency, percentage calculations, sample t-test, one-way-variance analysis and LSD test for determining groups creating the difference as a result of this analysis.

4. Results

55.1 % of the participants were midwives, and 44.9 % were nurses. 97.7 % were females and 54.6 % were university graduates. 23.6 % of them had 6-10 years of work experience. 91.7 % stated they did not live in a different culture. 50.5 % reported they did not speak a foreign language or their language level was poor (Table 1).

Table 1. The distribution of the participants' features

Features	n	%
Job		
Midwife	119	55.1
Nurse	97	44.9
Gender		
Female	5	97.7
Male	211	2.3
Age		
18-24	21	9.7
25-34	84	38.9

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35-44	87	40.3
45 and over	24	11.1
Education		
High school	31	14.4
Undergraduate	53	24.5
Graduate	118	54.6
Post graduate	14	6.5
Area of work		
Policlinic	34	15.7
Clinic	52	24.1
Field of expertise*	130	60.2
Work experience		
1-5 years	44	20.4
6-10 years	51	23.6
11-15 years	32	4.6
16 years and over	89	41.2
Lived in a country with a different culture		
Yes	18	8.3
No	198	91.7
Speaks a foreign language		
Very poor or does not speak at all	109	50.5
Intermediate or over	107	49.5

* Adult intensive care, High risk pregnancy, Giving birth, Emergency, Neonatal intensive care, Delivery room

69.4 % of the participants said that they had provided health care to asylum seekers before (Table 2). Although not presented in the table, 28.2 % of those who stated they had provided care reported that they felt helpless, 22.5 % felt pity, and that 15.5 % anger and resentment. 69.9 % of the health care providers to asylum seekers said that there were negative sides of providing health care to asylum seekers, and 49.1 % stated it had positive sides (Table 2). While the rate of those who reported there were positive sides of providing health care to asylum seekers was 58.8 % in nurses, it was 41.2 % in midwives, and the difference between the groups was statistically significant (p=0.007). The negative sides of providing health care to asylum seekers were reported by the participants as follows: 56.4 % of the participants said that they could not provide health care due to language obstacles, 28.8 % stated the likelihood of incomplete or wrong translation by the interpreter during communication with woman, and 8.3 % mentioned the increase in workload as negative side. On the other hand, the participants who stated there were positive sides gave more than one answer. 83.3 % said feeling the spiritual satisfaction of helping a woman and her baby who were in need was the positive side. 42.5 % claimed experiencing different cultures, and 30 % said learning the traditional practices of different cultures was the positive side. 97.3 % of the participants who reported they had provided health care to asylum seekers before stated they experienced difficulties while giving care. The participants who said they had difficulties gave multiple answers. 98.6 % mentioned language problem. 67.8 % stated they had to spend more time for the patient, and 57.5 % said the asylum seekers had problems in complying with the treatment. 19.1 % of those who stated they experienced problems said they did not look for a solution, and 80.9 % claimed they tried to solve the problems. 96.3 % of the participants who claimed to have tried to solve the problems stated they tried to solve the language problem, 37.9 % said they spent more time for these patients to provide better care, and 12.1 % stated they tried to learn the cultural

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features and values of the individuals. When the participants were asked about their advices for minimizing these problems, they gave multiple answers. They recommended the following solutions: 67.2 % said the policlinic and clinic rooms used to provide service to asylum seekers should be separate; 62.8 % stated health care personnel who can speak different languages should be assigned to the services giving care to asylum seekers; 45.3 % said health care workers should be trained about providing services to asylum seekers; 38 % suggested the help of individuals who knew the country where asylum seeker women came from should be requested so as to increase the communication; and 39.4 % said guides should be developed regarding the services provided to asylum seekers (Table 2).

Table 2 (i). Attributes Relating to Providing Care to Asylum Seekers by the Participants (n=216)

Attributes	n	%
Provided care to asylum seekers before		
Yes	150	69.4
No	66	30.6
Would like to provide care to asylum seekers		
Yes	126	58.3
No	90	41.7
Thinks there are positive sides to providing care to asylum seekers		
Yes	106	49.1
No	110	50.9
Thinks there are negative sides to providing care to asylum seekers		
Yes	151	69.9
No	65	30.1
Experienced difficulties while providing care to asylum seekers		
Yes	146	97.3
No	4	2.7
Difficulties while providing care to asylum seekers (n=146)*		
Unable to understand women's problems and complaints due to language barriers	144	98.6
Experienced difficulty in having women adapt treatment	84	57.5
Having difficulty in follow-ups	57	39.0
Having to spend more time for a patient and having setbacks in other taks	99	67.8
Being unable to allocate enough time for the patients due to workload	50	342
No health insurance	37	25.3
Unwilling to give care due to the existence of hygiene problems	49	33.6
Unfamiliar with giving health care to asylum seeker women	22	15.1
Looking for solutions when experienced problems while providing care to asylum seekers (n=146)		
Yes	110	80.9
No	26	19.1
Things done to reduce the difficulties experienced (n=110)*		
Trying to solve the language barrier (asking for an interpreter, receiving help from somebody who can speak the language, etc.)	106	96.3
Spending more time for the asylum seeker patient	47	37.9
Learning about the cultural features and values of the asylum seekers	15	12.1
Decrease in the number of patients given care when providing care to asylum seekers	4	3.2
Unwilling to work in service areas where asylum seeker women often come, leaving the place	3	2.4

*Multiple responses were given to the questions and percentages were calculated based on.

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Table 2 (ii). Attributes Relating to Providing Care to Asylum Seekers by the Participants (n=216)

Attributes	n	%
Recommendations to reduce the difficulties experienced *		
Separating the policlinics and clinics where asylum seekers consult	92	67.2
Assigning personnel who can speak different languages to ensure communication in health institutions	86	62.8
Training health care personnel and ensuring that they only look after the asylum seekers	62	45.3
Preparing guides to help asylum seeker women	54	39.4
To increase the communication, obtaining help from volunteers who know the cour where the asylum seeker women come from	52	38.0
Organizing educational meetings and seminars on approaching asylum seeker wome	33	24.1
All services should be free	7	5.1
Received training on intercultural communication		
Yes	11	5.1
No	205	94.9
Willing to receive training on intercultural communication		
Yes	139	64.4
No	77	35.6

*Multiple responses were given to the questions and percentages were calculated based on.

The participants were asked whether they wanted to give care to asylum seekers. The rate of positive responses to this question was 58.4 % (Table 2). This rate was 65.4 % in those who could speak a foreign language at an intermediate level or above, and 51.4 % in participants whose foreign language was poor or who couldn't speak a foreign language at all, and the difference was found statistically significant ($p=0.036$). When the reasons of reluctance to provide health care to asylum seekers were examined, it was found that 60 % stated they experienced communication problems, and 15 % thought looking after women seeking asylum would adversely influence the quality of the health care to be offered to the woman citizens of our country. 94.9 % of the participants reported that they had not taken any training on intercultural communication, whereas 64.4 % said they wanted to be trained on it (Table 2). The rate of those who wanted to be trained on intercultural communication was 79.4 % in nurses and 52.1 % in midwives, and the difference between the groups was found to be statistically significant ($p<0.001$).

The mean ISS score of the participants was 75.73+10.1. There was a statistically significant difference between ISS mean scores and participants' age, education status, speaking a foreign language, being willing to be trained on intercultural communication, thinking there are positive sides of providing health care to asylum seekers, being willing to provide services to asylum seekers, and looking for solutions for problems met during providing health care to asylum seekers ($p<0.05$) (Table 3; Table 4).

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Table 3. The Distribution of ISS mean scores based on the participants' features

Features	n	ISS X ± SD	Analysis
Job			
Midwife	119	82.23+12.05	t=-0,856
Nurse	97	83.50+9.14	p=0.393
Age			
18-24(a)	21	87.71+8.18	F=2.864
25-34 (b)	84	83.82+9.71	**p=0.038**
35-44 (c)	87	81.52+11.58	(a-c; a-d)
45 and over (d)	24	79.58+12.44	
Education			
High school (a)	31	81.19+10.09	F=3.077
Undergraduate (b)	53	82.09+12.49	**p=0.029**
Graduate (c)	118	82.57+9.29	**(a-b;a-c;a-d)**
Post graduate (d)	13	91.00+14.83	
Area of work			
Policlinic	34	83.32+14.2	F=0.156
Clinic	52	83.30+10.8	p=0.856
Area of expertise	130	82.46+9.87	
Work experience			
1-5 years	44	85.11+9.04	F=1.155
6-10 years	51	83.01+8.89	p=0.328
11-15 years	32	80.65+12.18	
16 years and over	89	82.31+12.05	
Lived in a country of different culture			
Yes	18	86.77+11.30	t=1.423
No	198	82.48+10.76	p=0.156
Speaks a foreign language			
Poor or not at all	109	80.77+11.06	t=0.534,
Intermediate or over	107	84.86+10.24	**p=0.005**

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Table 4. The Distribution of ISS mean scores based on attributes about providing care to asylum seekers by participants

Attributes	n	ISS X ± SD	Analysis
Provided care to asylum seekers before			
Yes	150	82.74+10.82	t=-0.134
No	66	82.95+10.93	p=0.894
Would like to provide care to asylum seekers			
Yes	126	86.03+10.72	t=5.520
No	90	78.28+9.32	**p<0.001**
Thinks there are positive sides to providing care to asylum seekers			
Yes	106	86.35+11.21	t=4.985
No	110	79.38+9.29	**p<0.001**
Thinks there are negative sides to providing care to asylum seekers			
Yes	151	82.67+10.38	t=-0.268
No	65	83.10+11.89	p=0.789
Experienced difficulties while providing care to asylum seekers			
Yes	146	82.93+10.90	t=1.312
No	4	75.75+3.30	p=0.192
Looking for solutions when experienced problems while providing care to asylum seekers			
Yes	110	84.63+10.73	**t=-3.390**
No	26	77.50+9.27	**p=0.001**
Received education on intercultural communication			
Yes	11	87.36+13.35	t=1.435
No	205	82.56+10.67	p=0.153
Willing to receive education on intercultural communication			
Yes	139	85.03+10.87	**t=4.220**
No	77	78.77+9.58	**p<0.001**

5. Discussion

Asylum seekers are among the most vulnerable groups in terms of health conditions such as difficult living conditions, housing, problems related with nutrition, difficulties in accessing health and social services, violence, etc (Burnett and Pell, 2001:25-31). Therefore, this issue should be handled primarily in the services provided by midwives and nurses. In our study, nearly seven out of ten participants provided services to asylum seekers, about three out of ten stated they felt helpless while providing care, and about two said they felt pity, anger or frustration. In a study investigating the experiences of student nurses working in an asylum seeker camp, it was reported that the participants felt helpless because they were inadequate to solve asylum seekers' problems (Henriksen, 2014:279-292). It was determined in another study that the midwives providing health care to asylum seekers felt furious and disappointed due to ignorance, fear and increasing workload (Tobin and Murbhy-Lawless, 2014:159–169). The results of the study were in line with the findings of our study, in that nurse and midwives experienced negative feelings while providing health care to asylum seekers. Beşer and Tekkaş-Kerman (2017) reported that the negative attitudes of health professionals will prevent access to health services for migrants. Therefore it is thought that conditions should be organized to help nurses and midwives experience positive feelings. Almost all of the participants claiming to have provided health care to asylum seekers stated they had

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difficulties while providing health care, and the majority said that there were negative sides of providing health care to asylum seekers in parallel with these problems. These findings are of significance in terms of indicating the necessity to study the problems of nurses and midwives providing health care to asylum seekers. Almost all of those who stated they experienced difficulties said they had language problems. In line with this finding, more than half of those who said there were negative sides of providing health care to asylum seekers found being unable to provide health care due to language barriers as a negative side. Nearly three out of ten participants stated the likelihood of incomplete or wrong translation during communication with asylum seeker women was the negative side. In addition, it is also a significant finding that majority of those who said that they would not like to give health care to asylum seekers stated the reason for this was communication problems. The finding of this study indicated that the language barrier in providing care to asylum seekers caused midwives and nurses to have difficulty in providing care, midwives and nurses were worried about giving incomplete or inaccurate care due to communication problems, and that some of them did not want to provide health care for this reason. Similar to our study, Kelaher and Manderson (2000) determined that such issues as language barriers and problems arising from cultural differences were experienced in health care given to women migrating in Australia. Danç and güney (was determined in their study that nearly all nurses mentioned the language barrier in the care of refugees. In addition, they reported nurses urgently need interpreters who could make medical translation in the hospital. It was also reported in another study that problems stemming from language barriers were experienced in providing health care in places where immigrant population was concentrated (Kale and Syed, 2010:187-191). Bischoff et al. (2003) determined in their study that language compliance between nurses and asylum seekers was found 55 % satisfactory. This may show that language barrier does not only cause problems while giving health care to asylum seekers in our country, but also all over the world.

It is important that about two out of ten participants stating they had difficulty providing health care to asylum seekers claimed that they did not look for a solution when they experienced a difficulty. It is reported in the literature that increasing the quality of nursing services was possible by applying solutions appropriate for the patient and the family (Taşçı, 2005:73-78). It is important that nurses and midwives should provide a culture-sensitive health care, and look for solutions for the problems emerging during the provision of services. Otherwise, it is thought that receiving a quality care will not be possible for asylum seekers. When women want to benefit from health care services, they may not receive qualified and adequate health care due to several reasons stemming from language barriers such as being unable to express themselves, being unable to be understood, misunderstanding, and uncertainty (Çalım-İldam et al., 2012:11-19). Leininger and McFarland (2002) reported that the existence of language barriers in intercultural communication brought about undesired outcomes in health care. It is emphasized in another study that language barrier decreased the quality of health care services and therefore the consultancy of a professional interpreter was important (Bischoff et al., 2003:503-512). It was determined in this study that almost all of the midwives and nurses who stated they tried to solve the problems about asylum seekers tried to overcome the language problem and they received help from an interpreter or somebody good at the language. Nurses' perceiving the language problems and communication barrier as a challenge and looking for ways to solve it was thought to be significant.

Nearly seven out of ten participants stating they had difficulty providing health care to asylum seekers claimed that they had to spend more time for patients, and that they experienced setbacks in other tasks. In a study carried out by Tobin et al. midwives providing maternity care to asylum seeker women stated that they spent more time while giving care to women seeking asylum due to language barriers, and that this caused extra workload (Tobin and Murbhy-Lawless, 2014:159-169). It is necessary that the characteristics and care requirements of patients should be determined and the planning should be made accordingly when employing care providers (Bal

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Demiröz, 2014:148-154). Midwives and nurses should make their plans about how many patients they will look after and how much time they will spend for each patient considering the requirements of the individuals they provide health care to. It is thought that considering the requirements emerging due to cultural diversities is important during planning stage. The cultural values, beliefs and practices of a patient are important parts of total care. 12.1 % of the participants in the study experiencing difficulties stated they tried to learn the cultural characteristics and values of the individuals for the solution of the problems experienced while giving care. It was reported in a study investigating the beliefs of Somalian immigrant women about pregnancy and birth that these women should be given health care with a viewpoint involving their cultural, religious and scientific beliefs (Hill et al., 2012:72-78). In another study by Hamilton and Essat (2014) investigating the experiences and expectations of minority groups related with nursing care, the participants stated that the basic knowledge of nurses about cultural and religious practices was important in understanding their beliefs and practices. A large part of the participants stated that they did not receive education on intercultural communication, and that a considerable part wanted to get education on it. The rate of the nurses who wanted education on intercultural education was higher than that of midwives, and the difference between the groups was statistically significant. Similarly, the rate of nurses who stated there were positive sides of providing care to asylum seekers was higher than that of midwives, and the difference between the groups was statistically significant. To provide adequate cultural care in nursing, cultural theories, models, and evaluation guides for international use were developed by Leinger and many experts, and the studies have been going on (Leininger and McFarland, 2002; Dufy, 2001:487-495; Totumluoğlu, 2004:47-57).

Although the term transcultural nursing has existed in the nursing literature both in the world and in our country, the term transcultural midwifery has recently begun to be discussed. For this reason, the awareness of culture-sensitive care provision in midwives is thought not to be as satisfactory as that in nurses. It is recommended that models about transcultural midwifery should be developed, and that awareness and knowledge level in both nurses and midwives should be boosted with pre and post graduation education.

The recommendations of individuals who state they have experienced some difficulties during the solution of a problem are thought to be important. A significant part of the participants in this study suggested some solutions for the problems such as separate policlinic and clinic rooms should be allocated for the asylum seekers; the health care personnel who can speak different languages should be used in services provided to asylum seekers; and the help of volunteers who knew the country where the women came from should be asked for so as to enhance the communication. It is thought that taking advantage of an interpreter in ensuring communication was important, however that the choice of these individuals needed attention. It was reported in a study that assigning non-professional people as interpreter caused serious problems such as misunderstanding, and being unable to understand medical terms (Kale and Syed, 2010:187-191). It was also recommended in another study that a person who could speak the language well, or a friend or relative of the immigrant could be helpful to overcome the communication problem, instead of a professional interpreter who could not speak the language well. It is thought that questioning the qualities of the person whose support is received so as to handle language problems is important to prevent medical mistakes, and that the standards regarding interpreter use should be improved.

About half of the participants in the study recommended that health care personnel should be trained on providing care to asylum seekers and the trained personnel should only look after asylum seeking patients. In addition, 39.4 % of the participants suggested that guides should be developed regarding the services to be provided to asylum seekers. The statement by the majority of the participants in the study that they did not receive education on intercultural communication and the mean ISS score which was not at a desired level was thought to support the necessity of this recommendation. It was reported in Kim (2013) carried out with 285 nurses that strategies

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should be developed and educational programs should be prepared so as to strengthen the intercultural self-efficacy of nurses and enhance the success of culture-sensitive care. It was also reported in the literature that all health care professionals should go through sustainable education so that people belonging to ethnic minority groups could access health care services and the quality of health care could be improved (Braithwaite and Majumdar 2006:470-479; Betancourt, 2006:499-501; Menonet al., 2001:439-450), and that giving suitable education to nurses was of critical significance in order to ensure a culturally competent and safe care (NCCRI and IHSMI, 2002).

In the current study, there was a statistically significant difference between ISS mean scores and the participants' age, education status, and status of speaking a foreign language ($p<0.05$). Similar to our study, it was reported in Aktaş et al. (2015) that speaking a foreign language increased cultural sensitivity. It was determined in Jeffreys and Doğan (2012) that speaking a foreign language boosted students' self-confidence and made a positive contribution to patient care. In addition, according to this study, as the cultural sensitivity increased, the state of demanding for education on intercultural communication, the state of considering providing health care to asylum seekers positive, and the state of looking for solutions for the problems experienced while providing service to asylum seekers increased as well. In order to ensure intercultural care approach, it is necessary to develop knowledge, sensitivity and awareness specific to other cultures (White, 2003:326-332). Therefore, it is thought that developing strategies to increase the cultural sensitivity of nurses is important.

6. Conclusions and recommendations

It was determined in our study the participants' ISS mean score was 75.73+10.1. Participants' age, education status, and status of speaking a foreign language were affectting factor to ISS mean scores. Almost all of the midwives and nurses providing health care to asylum seekers experienced problems while providing services, and that language was the biggest challenge. It was recommended in the study that the units used to provide services to asylum seekers should be specifically allocated, the personnel should be trained on this topic and increasing the cultural sensitivity, that guides should be developed for the solution of these problem.

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